MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (13-A)

12872

CERTIFICATE OF DEATH

Reg. Dist. No. 355

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County WORCESTER
City or town BERLIN
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 6 YEARS
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State MARYLAND County WORCESTER
City or town BERLIN
(If outside city or town limits, write RURAL and give nearest town)
Street No. PITTS.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME ROBERT C. BETHELL

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
MALE	WHITE	MARRIED

6.(b) Name of husband or wife LENA RAYNE BETHELL
6.(c) If alive, give age 65 years

7. Birth date of deceased (mo., day, yr.) AUG. 22, 1856

8. AGE: Years	Months	Days	If less than one day
89	3	9	hrs. min.

9. Birthplace BOONVILLE INDIANA. (Town, county, and state)
10. Usual occupation RETIRED TELEPHONE EMPLOYEE
11. Industry or business
FATHER 12. Name UNION BETHEL
13. Birthplace BOONVILLE IND.
MOTHER 14. Maiden name EVA MAFFETT PARRETT
15. Birthplace EVANSVILLE IND.
16. Informant MRS. C. W. RANDALL
Address MONTCLAIR, N. J.
17. BURIAL (Burial, cremation, or removal. Which?) Date thereof 12/5/45 (month) (day) (year)
Cemetery or crematory EAST RIDGELAWN CEM.
Location DELAWANNA N. J.
18. Funeral director Anna A. Burbage
Address Berlin, Md.
19. 12-4-45 (Date rec'd by registrar) Helen F. Hayward Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 1 1945 at M

21. I CERTIFY that death occurred on the date above stated, that I attended deceased from Nov 30 1945 to 19 and that I last saw h alive on Dec 1-45 19

Immediate cause of death	DURATION
Acute Uremia	
Due to Chronic Int Nep.	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Clifford E. Abbott M. D. or other
Address Berlin Md. Date signed 12-2-45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 109

CERTIFICATE OF DEATH

12873 Reg. Dist. No. 350

1. PLACE OF DEATH.
County: Worcester
City or town: Rural Pocomoke Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 9 months
Hospital, institution, or street address where death occurred: —
How long in hospital or institution? —

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Worcester
City or town: Rural Pocomoke
(If outside city or town limits, write RURAL and give nearest town)
Street No. —
(If rural, give LOCATION)
2.(a) If veteran, name war —

3. (a) FULL NAME Maurice B. Brittingham

3. (b) Social Security Number —

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6.(b) Name of husband or wife —
6.(c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) February 13-1945

8. AGE: Years	Months	Days	If less than one day
—	9	29	...hrs. ...min.

9. Birthplace: Salisbury Wicomico Maryland
(Town, county, and state)

10. Usual occupation —

11. Industry or business —

FATHER
12. Name: Maurice L. Brittingham
13. Birthplace: Maryland

MOTHER
14. Maiden name: Julia K. Hurley
15. Birthplace: Virginia

16. Informant: Mrs. Julia Brittingham
Address: Rural Pocomoke Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Dec 14-1945 (month) (day) (year)
Cemetery or crematory: Salem M. E. Cemetery
Location: Pocomoke Md.

18. Funeral director: Margaretta H. Watson
Address: Pocomoke Md.

19. Dec 17 1945 (Date rec'd by registrar) Anne E. White Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: December 12 1945, at 11 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec 12 1945, to Dec 12 1945
and that I last saw him alive on Dec 12 1945

Immediate cause of death	DURATION
Convulsions from	5 hours
Due to: Possibly Pneumonia	
Due to: Severe Cold	2 weeks
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ... Date of op. ...
Autopsy results: ...
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ... Date of ...
Where did injury occur? ... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) ...
Means of injury ... Injured at work?

23. SIGNATURE: W. E. Parsons M. D. or other
Address: Pocomoke City Md. Date signed 12/13/45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 351

1. PLACE OF DEATH:
County: Worcester.
City or town: Newark.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 40 years
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Worcester.
City or town: Newark
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Levin Albert Conner.

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	widowed

6.(b) Name of husband or wife: Alice Conner.
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Jan. 29, 1875

8. AGE:	Years	Months	Days	If less than one day
	70	10	16	hrs. min.

9. Birthplace: Snow Hill Wor. Co. Md.
(Town, county, and state)
10. Usual occupation: Retired Mill Owner.
11. Industry or business
FATHER 12. Name: Albert Conner.
13. Birthplace: Snow Hill, Md.
MOTHER 14. Maiden name: Elizabeth Jones.
15. Birthplace: Snow Hill, Md.
16. Informant: Mrs. Ruth Conner.
Address: Newark, Md
17. Burial (Burial, cremation, or removal. Which?) Date thereof: 12/17/45 (month) (day) (year)
Cemetery or crematory: Bowen
Location: Newark Md
16. Funeral director: Duncan A. Burbage
Address: Berlin Md.
19. 12/17/ 19 45 (Date rec'd by registrar) LeRoy Smith Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: December 15 1945, at M
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec. 1, 1945 to Dec 15 1945 and that I last saw h.. alive on Dec. 15 1945

Immediate cause of death	DURATION
Acute Lobar Pneumonia	5 da
Due to: Uremia	
Due to: Hypertension	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Clifford E. Schott M. D. or other
Address: Berlin Md. Date signed

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (46)

CERTIFICATE OF DEATH

12875

Reg. Dist. No. 351

WITHIN CORP.

1. PLACE OF DEATH:
County: Worcester
City or town: Snowhill
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? Several years.
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Worcester
City or town: Snowhill
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 18 Martin Street
(If rural, give LOCATION)
2.(a) If veteran, name war:

3. (a) FULL NAME: John Albert Dickerson

3. (b) Social Security Number: 218-16-6852

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Colo	Married

6.(b) Name of husband or wife: Mary Ellen Mason
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): October 15 - 1885

8. AGE: Years	Months	Days	If less than one day
ab. 60			hrs. min.

9. Birthplace: Accomack County, Va
(Town, county, and state)
10. Usual occupation: Laborer
11. Industry or business:

FATHER
12. Name: John Dickerson
13. Birthplace: Pocomoke Co, Va

MOTHER
14. Maiden name: Fannie Justis
15. Birthplace: Pocomoke Co, Va

16. Informant: Mary Ellen Dickerson
Address: Snow Hill, Md. #18 Martin Street

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Dec. 9th 1945 (month) (day) (year)
Cemetery or crematory: First Baptist Cemetery
Location: Mappsville, Virginia
18. Funeral director: J. E. Lecatt & Woman
Address: Accomac, Va

19. 12/8 19 45 R. Coy Smith
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: December 6 1945 at 2:00 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct 20 1945 to Dec 6 1945 and that I last saw h... alive on December 6 1945

Immediate cause of death	DURATION
Hemorrhage	
Due to: Carcinoma of Stomach	6 mos.
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Robert L. LaMar, M.D. M. D. or other
Address: Snow Hill Date signed: 12-8-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

Patent Office

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (12-B)

CERTIFICATE OF DEATH

12876

Reg. Dist. No. 355

1. PLACE OF DEATH:
County: Worcester
City or town: Whaleyville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 2 yrs.
Hospital, institution, or street address where death occurred: ✓
How long in hospital or institution? —

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Worcester
City or town: Whaleyville
(If outside city or town limits, write RURAL and give nearest town)
Street No. ✓
(If rural, give LOCATION)
2.(a) If veteran, name war —

3.(a) FULL NAME Cornelious Evans.

3.(b) Social Security Number —

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widower

6.(b) Name of husband or wife: Rozenia Evans ✓ 6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Sept 2, 1858.

8. AGE: Years	Months	Days	If less than one day
87	4	25	..... hrs. ..... min.

9. Birthplace: Worcester Md. (Town, county, and state)
10. Usual occupation: Farming
11. Industry or business: Farmer.

FATHER
12. Name: John Evans.
13. Birthplace: Md.

MOTHER
14. Maiden name: Eliza Melvin
15. Birthplace: Md.

16. Informant: Willie Evans.
Address: Whaleyville, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Dec 29 1945 (month) (day) (year)
Cemetery or crematory
Location: Whaleyville, Md.
18. Funeral director: M. Pasha Watson
Address: Whaleyville Md.

19. 12-29 1945 (Date rec'd by registrar) Helen F. Hayward Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Dec 27 1945, at 1:00 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19.... to ..... 19.... and that I last saw him alive on Dec 26 1945

Immediate cause of death	DURATION
Cerebral Hemorrhage	
Due to	
Due to	
Other conditions Chr. Nephritis	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....
Autopsy results: .....
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE Chas R. Fow M. D. or other
Address Berlin Md. Date signed 12-29-45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

12877

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (94a)

CERTIFICATE OF DEATH

Reg. Dist. No. 355

1. PLACE OF DEATH:
County: WORCESTER
City or town: BERLIN, R.D. ST MARTINS
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 55 1/2 YEARS
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: MARYLAND County: WORCESTER
City or town: BERLIN, R.D. ST MARTINS
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: JOHN HALL GILLIS

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
MALE	WHITE	MARRIED

6.(b) Name of husband or wife: RUTH M. GILLIS
6.(c) If alive, give age: 48 years

7. Birth date of deceased (mo., day, yr.): AUG. 4, 1890

8. AGE: Years	Months	Days	If less than one day: hrs.	min.
55	4	6		

9. Birthplace: ST. MARTINS, WOR. CO. MD.
(Town, county, and state)
10. Usual occupation: MERCHANT
11. Industry or business
FATHER 12. Name: E. JAMES GILLIS
13. Birthplace: ST. MARTINS MD.
MOTHER 14. Maiden name: ELIZABETH HALL
15. Birthplace: DELAWARE
16. Informant: MRS. JOHN H. GILLIS
Address: ST MARTINS, MD
17. BURIAL (Burial, cremation, or removal. Which?) Date thereof 12/13/45 (month) (day) (year)
Cemetery or crematory: BUCKINGHAM'S
Location: BERLIN, MD
18. Funeral director: Anna R. Burbage
Address: Berlin Md
19. 12-13- 1945 Helen E. Hayward
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: December 10th 1945 at 10:00 P.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....
and that I last saw h..... alive on ..... 19.....

	DURATION
Immediate cause of death: Coronary Occlusion	Sudden
Due to:	
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Frederick S. Tuttle, M.D.
M. D. or other
Address: Berlin Md Date signed 12/13/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (61)

CERTIFICATE OF DEATH

12878

Reg. Dist. No. 350

1. PLACE OF DEATH:

County: Worcester

City or town: Pocomoke

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 2 years

Hospital, Institution, or street address where death occurred: —

How long in hospital or institution? —

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Worcester

City or town: Pocomoke

(If outside city or town limits, write RURAL and give nearest town)

Street No.: Market Street

(If rural, give LOCATION)

2.(a) If veteran, name war:

3. (a) FULL NAME: Georgianna Susie Hasting

3. (b) Social Security Number: 218-20-5719

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	white	divorced

6.(b) Name of husband or wife: —

6.(c) If alive, give age: — years

7. Birth date of deceased (mo., day, yr.): November 14, 1892

8. AGE: Years: 53 Months: 1 Days: 0 If less than one day: hrs. min.

9. Birthplace: Gargathy Accomac Va. (Town, county, and state)

10. Usual occupation: maid

11. Industry or business:

FATHER — 12. Name: Samuel P. Wessells

FATHER — 13. Birthplace: Virginia

MOTHER — 14. Maiden name: Elizabeth Young

MOTHER — 15. Birthplace: Virginia

16. Informant: Mrs. J. D. Atkinson

Address: Ballahaven Va.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Dec 16-1945 (month) (day) (year)

Cemetery or crematory: Downing Cemetery

Location: Oak Hall Va.

18. Funeral director: Margaret H. Watson

Address: Pocomoke Md.

19. Dec 17 1945 (Date rec'd by registrar) Anne E. White Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Dec 14 1945, at 9:15 P.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from Dec 6 1945 to Dec 14 1945 and that I last saw h... alive on Dec 14 1945

Immediate cause of death	DURATION
(a) Uremic Hysteria	7 days
(b) Nephritis	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: C. E. Latchum M. D. or other

Address: Date signed: 12-15-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

12879

Reg. Dist. No. 355

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Worcester
City or town: Berlin
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Worcester
City or town: Berlin.
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME: David Arnold Henry.

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	colored	married

6.(b) Name of husband or wife: Mrs. Isabel Henry.
6.(c) If alive, give age: 29 years

7. Birth date of deceased (mo., day, yr.): JUNE 25, 1908

8. AGE: Years	Months	Days	If less than one day
37	5	24	hrs. min.

9. Birthplace: Maryland
(Town, county, and state)
10. Usual occupation: Barber
11. Industry or business
FATHER 12. Name: Isaac J. Henry.
13. Birthplace: Berlin Md
MOTHER 14. Maiden name: Lucie Mullen
15. Birthplace: Berlin Md
16. Informant: Mrs. David A. Henry
Address: Berlin Md
17. Burial
(Burial, cremation, or removal. Which?) Date thereof 12 | 22 | 45 (month) (day) (year)
Cemetery or crematory: St. Pauls (Col)
Location: Berlin Md.
18. Funeral director: Duma A. Bunbury
Address: Berlin Md.
19. 12-22-45 Helen F. Hayward
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: December 19 1945 at 6:45 A. M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ... 19... to ... 19...
and that I last saw h... alive on ... 19...

Immediate cause of death	DURATION
Chronic Tuberculosis	13 yrs
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide. Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury. Injured at work?

23. SIGNATURE: [signature] M. D.
M. D. or other
Address: Berlin Md. Date signed 12-20-45

12880

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 83-D

CERTIFICATE OF DEATH

Reg. Dist. No. 350

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Worcester
City or town: Pocomoke City Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 77 years
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Worcester
City or town: Pocomoke City Md.
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME: Sade Ward Stevenson

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	Colored	Widowed.

6.(b) Name of husband or wife: John T Stevenson
6.(c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.): Unknown 1868

8. AGE: Years 77 | Months — | Days — | If less than one day ____ hrs. ____ min.

9. Birthplace: Pocomoke Worcester Md.
(Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business: —

FATHER
12. Name: Samuel Ward
13. Birthplace: Maryland

MOTHER
14. Maiden name: Anne Elliott
15. Birthplace: Maryland.

16. Informant: Lizzie Purel
Address: Pocomoke Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Dec 7 - 1945 (month) (day) (year)
Cemetery or crematory: Hillcrest Cemetery
Location: Rural Pocomoke Md.

18. Funeral director: Margurite Silvertooth
Address: Pocomoke Md.

19. Dec. 7, 1945 (Date rec'd by registrar) Anne E. Pilts Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Dec 3 1945 at 3 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec 1st 1945 to Dec 3rd 1945
and that I last saw h alive on Dec 1st 1945

Immediate cause of death	DURATION
Hemiplegia	3 days
Due to: Arteriosclerosis	5 K.
Other conditions: Varicose ulcers both legs.	3 yrs

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: N. E. Parsons M.D.
Address: Pocomoke City Md. M. D. or other
Date signed 12/4/45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

12881

Reg. Dist. No. 355

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Worcester

City or town: Berlin, R.F.D. 1

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 24 years

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Worcester

City or town: Berlin R.F.D. 1

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME: Guy Russell Holland.

3. (b) Social Security Number: 213-22-7207

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	married.

6.(b) Name of husband or wife: Dorothy L. Holland

6.(c) If alive, give age: 20 years

7. Birth date of deceased (mo., day, yr.): Dec. 9, 1921

8. AGE:

Years	Months	Days	If less than one day
24	0	2	...hrs. ...min.

9. Birthplace: Berlin Wor Co. Md.

(Town, county, and state)

10. Usual occupation: Carpenter.

11. Industry or business

FATHER

12. Name: Jesse Holland.

13. Birthplace: Berlin Md R.F.D.

MOTHER

14. Maiden name: Eva Roach

15. Birthplace: Berlin Md

16. Informant: Mrs. Russell Holland

Address: Berlin Md R.F.D.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: 12/14/45 (month) (day) (year)

Cemetery or crematory: Buckingham

Location: Berlin Md.

18. Funeral director: Irma A. Burbage

Address

19. 12-14 1945 (Date rec'd by registrar) Helen L. Hayward Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Dec 16, 1945. 19... at ...M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from August 1944 19... to day of death and that I last saw him alive on Dec 9, 1945 19...

	DURATION
Immediate cause of death: (a) Pulmonary tuberculosis.	9 yrs.
Due to:	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: Grant K. Loomis M.D. M. D. or other

Address: Villards Date signed: 12-13-45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Diat. No. 350

1. PLACE OF DEATH:
County: Worcester
City or town: Rural Pocomoke
(If outside city or towo limits, write RURAL and give nearest towo)
How long in above place of death? 40 Years
Hospital, institution, or street address where death ocurred: —
How long in hospital or institution? —

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newboro iofonts give residence of mother)
State: Maryland County: Worcester
City or town: Rural Pocomoke Md.
(If outside city or towo limits, write RURAL ond give nearest town)
Street No. —
(If roral, give LOCATION)
2.(a) If veleran, name war —

3.(a) FULL NAME: Margaret Caloine Howerton

3.(b) Social Security Number: —

4. Sex: Female
5. Color or race: White
6.(a) Single, married, widowed, or divorced: Single
6.(b) Name of husband or wife —
6.(c) If alive, give age — years
7. Birth date of deceased (mo., day, yr.): July 9, 1876
8. AGE: Years: 69 Months: 5 Days: 9 If less than one day: — hrs. — min.
9. Birthplace: Raleigh N.C. (Town, county, ond stote)
10. Usual occupation: Mng and owns poultry farm
11. Industry or business
FATHER 12. Name: Wm Stanley Howerton
13. Birthplace: Virginia
MOTHER 14. Maiden name: Amanda Rowe
15. Birthplace: N. C.
18. Informant: Miss Clara Mattlage
Address: Rural Pocomoke Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof: Dec 12 1945 (month) (day) (year)
Cemetery or crematory: Presbyterian Cemetery
Location: Pocomoke Md.
18. Funeral director: Margaritte & Watson
Address: Pocomoke Md.
19. Dec. 12 1945 (Date rec'd by registrar) Anne E. White Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: November 9 1945, at 6 P M
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec 9 1945 to Dec 9 1945 and that I last saw h— alive on Dec 9 1945

	DURATION
Immediate cause of death: Sudden collapse	Instt
Due to: Angina Pectoris	17y
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: — Date of op. —
Aotopsy results —
PHYSICIAN: Please underlioe the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide — Date of —
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) —
Means of injury — Injured at work?

23. SIGNATURE: J. W. Nelson M. D. or other
Address: Pocomoke City Date signed: 12/10 45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

12883

Reg. Dist. No. 353

1. PLACE OF DEATH:
County Worcester
City or town Bishop
(If outside city of town limits, write RURAL and give nearest town)
How long in above place of death? 16 years
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md County Worcester
City or town Bishop, Md
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Rosie Hall Ivory

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	colored	married

6.(b) Name of husband or wife Joe Ivory
6.(c) If alive, give age 71 years
7. Birth date of deceased (mo., day, yr.) 1908

8. AGE:

Years	Months	Days	If less than one day
37			hrs. min.

9. Birthplace Wilmington, N.C.
(Town, county, and state)
10. Usual occupation Midwife
11. Industry or business

FATHER
12. Name unknown
13. Birthplace

MOTHER
14. Maiden name Della Hall
15. Birthplace Wilmington, N.C.

16. Informant Joe Ivory
Address Bishop, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Dec. 4, 1945 (month) (day) (year)
Cemetery or crematory Mission Cemetery
Location Bishop, Md.

18. Funeral director Margarette V. Watson
Address Pocomoke City, Md.

19. Dec. 4 1945 Mrs Ray Berger registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 2 1945 at 8 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept 1945, to Dec 2 1945
and that I last saw h alive on 1945

Immediate cause of death	DURATION
Congestive Heart Failure	1 wks
Due to Hypertension Cardio-vascular Disease	3 yrs
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Robert H Long M.D
M. D. or other
Address Frankford Del Date signed 12-3-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 83-a

CERTIFICATE OF DEATH

12884

Reg. Dist. No. 351

WITHIN CORPORATE LIMITS

1. PLACE OF DEATH:
County: Worcester
City or town: Snow Hill
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 1 year 4 mo.
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Worcester
City or town: Snow Hill
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war: No

3.(a) FULL NAME: William H. Lank

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widowed

6.(b) Name of husband or wife: Elizabeth Lank
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): July 29 - 1860

8. AGE: Years	Months	Days	If less than one day
85	4	29	hrs. min.

9. Birthplace: Newark Worcester Md
(Town, county, and state)
10. Usual occupation: Farmer
11. Industry or business:

FATHER 12. Name	John Lank
FATHER 13. Birthplace	Maryland
MOTHER 14. Maiden name	Eliza Bradford
MOTHER 15. Birthplace	Maryland

16. Informant: Mrs. Granville Lank
Address: Snow Hill, Md
17. Burial (Burial, cremation, or removal. Which?) Date thereof Dec. 31/45 (month) (day) (year)
Cemetery or crematory: Bowen
Location: Newark
18. Funeral director: Hearne & Dennis
Address: Snow Hill, Md
19. 12/29/45 (Date rec'd by registrar) LeRoy Smith Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: December 28 19 45 at 5-50 P. M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 12/26/45 19 to 12/28/45 19
and that I last saw h[illegible] alive on 12/28/45 19

Immediate cause of death	DURATION
Arteriosclerosis	unknown
Apoplexy	2 days
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Paul Cohen M.D.
M. D. or other
Address: Snow Hill Date signed 12/29/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (61)

CERTIFICATE OF DEATH

12885

Reg. Diat. No. 355

1. PLACE OF DEATH:

County: Worcester

City or town: Berlin

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 7 days

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md County: Worcester

City or town: Berlin

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME: Nancy Elizabeth Palmer.

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	married

6.(b) Name of husband or wife: Harry E. Palmer.

6.(c) If alive, give age: 75 years

7. Birth date of deceased (mo., day, yr.): Feb. 14, 1872

8. AGE: Years	Months	Days	If less than one day
73	10	0	hrs. min.

9. Birthplace: Berlin Worc. Co. Md (Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business

FATHER — 12. Name: James W. Payne.

13. Birthplace: Berlin Md.

MOTHER — 14. Maiden name: Phoebe Ann Phillips

15. Birthplace: Berlin Md.

16. Informant: Mrs. H. E. Palmer. Address: Berlin Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 12/16/45 (month) (day) (year)

Cemetery or crematory: Evergreen.

Location: Berlin Md.

18. Funeral director: Anna A. Burbage

Address: Berlin Md.

19. 12-16- 1945 (Date rec'd by registrar) Helen F. Hayward Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: December 14 1945 at 8:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 1943 19 to Dec 14 19 45 and that I last saw her alive on Dec 14 19 45

Immediate cause of death	DURATION
Chronic myocarditis	10 yrs.
Due to: Generalized Arteriosclerosis	20 yrs.
Due to: Diabetis Mellatis	15 yrs.
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: H. Mueller M.D. M. D. or other

Address: Berlin Md. Date signed 12/15/45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 18

CERTIFICATE OF DEATH

12886

Reg. Dist. No. 350

1. PLACE OF DEATH:
County: Worcester
City or town: Rural Pocomoke
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 81 Years
Hospital, Institution, or street address where death occurred: —
How long in hospital or institution? —

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Worcester
City or town: Rural Pocomoke
(If outside city or town limits, write RURAL and give nearest town)
Street No. —
(If rural, give LOCATION)
2.(a) If veteran, name war: —

3.(a) FULL NAME: Harvey Thompson Pilchard

3.(b) Social Security Number: —

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widowed

6.(b) Name of husband or wife: Sally Pilchard
6.(c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.): October 17, 1864

8. AGE: Years	Months	Days	If less than one day
81	2	13	____ hrs. ____ min.

9. Birthplace: Pocomoke Worcester Md (Town, county, and state)
10. Usual occupation: Farming
11. Industry or business: —

FATHER
12. Name: Wrixram S. Pilchard
13. Birthplace: Maryland

MOTHER
14. Maiden name: Emma Jones
15. Birthplace: Maryland

16. Informant: Willard Pilchard
Address: Rural Pocomoke, Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Jan 2, 1946 (month) (day) (year)
Cemetery or crematory: Presbyterian Cemetery
Location: Pocomoke Md

18. Funeral director: Margaretta S. Wilson
Address: Pocomoke Md

19. Jan. 2 1946 (Date rec'd by registrar) Anne E. White Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: December 30 1945, at 8:45 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb 5 1944, to Dec 30 1945
and that I last saw h— alive on Dec 29 1945

Immediate cause of death	DURATION
Uremic Coma	1 wk
Due to: Chronic Interst Nephritis	2 yrs
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: —
Date of op. —
Autopsy results: —
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of —
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, Industry, public place (where?) —
Means of injury Injured at work?

23. SIGNATURE: J. M. Nelson M. D. another
Address: Pocomoke Md Date signed: 11-4-46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

12887

Reg. Dist. No. 355

1. PLACE OF DEATH:
County: Worcester
City or town: Berlin R.F.D.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 4 years.
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants, give residence of mother)
State: Md County: Worcester
City or town: Berlin R.F.D.
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Curtis Purnell.

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	colored	—

6.(b) Name of husband or wife:
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Aug. 30, 1941

8. AGE: Years	Months	Days	If less than one day
4	3	7	hrs. min.

9. Birthplace: Maryland.
(Town, county, and state)

10. Usual occupation:

11. Industry or business:

FATHER
12. Name: Mc Kinley Purnell
13. Birthplace: Berlin Md R.F.D

MOTHER
14. Maiden name: Sarah Belle Purnell
15. Birthplace: Berlin Md R.F.D.

16. Informant: Mc Kinley Purnell
Address: Berlin Md R.F.D.

17. Burnaid (Burial, cremation, or removal. Which?) Date thereof 12/8/45 (month) (day) (year)
Cemetery or crematory: St. Pauls (Col)
Location: Berlin Md

18. Funeral director: Rum A. Burbage
Address: Berlin Md.

19. 12-8-45 (Date rec'd by registrar) Helen F. Hayward, Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 12-7 19 45 at 5 A.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from 12-6 19 45, to 12-7 19 45
and that I last saw him alive on 12-6-45 19

Immediate cause of death	DURATION
Acute Lobar Pneumonia	5 days
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Clifford E. Sokett, M. D. or other
Address: Berlin Md Date signed 12-7-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
DEC 10 1965
BUREAU V.S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (83a)

CERTIFICATE OF DEATH

12883

Reg. Diat. No. 351

1. PLACE OF DEATH:
County: Worcester
City or town: Snow Hill Rural #2
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Worcester
City or town: Snow Hill Rural #2
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war: No

3. (a) FULL NAME: Harris H. Pusey

3. (b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Edna A. Pusey
6.(c) If alive, give age: 42 years

7. Birth date of deceased (mo., day, yr.): Sept. 30 - 1901

8. AGE: Years	Months	Days	If less than one day
44	2	23	hrs. min.

9. Birthplace: Snow Hill Worcester MD
(Town, county, and state)
10. Usual occupation: Farmer
11. Industry or business: Own Farm
FATHER 12. Name: Jacob H. Pusey
13. Birthplace: Delaware
MOTHER 14. Maiden name: Sarah Elizabeth Walls
15. Birthplace: Delaware
16. Informant: Mrs Edna A. Pusey
Address: Snow Hill MD Rural #2
17. Burial (Burial, cremation, or removal. Which?) Date thereof: Dec 26 45 (month) (day) (year)
Cemetery or crematory: Christian
Location: Snow Hill MD
18. Funeral director: Pearne & Dennis
Address: Snow Hill MD
19. 12-24-45 (Date rec'd by registrar) 19 45 R. Roy Smith Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: December 23 19 45 at 5-15 P.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....
and that I last saw h..... alive on ..... 19.....

Immediate cause of death	DURATION
Arteriosclerosis & C.	1 yr
Cerebral Hemorrhage	1 hr
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ..... Date of .....
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury: ..... Injured at work?

23. SIGNATURE: Paul Chen M.D
M. D. or other
Address: Snow Hill Date signed: 12/24/45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

(I) MARGIN RESERVED FOR BINDING

(M)

Evidence for change of age of deceased is shown on FEB 18 1946

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

12889

Reg. Diat. No. 355

ILM No. 100

1. PLACE OF DEATH:
County: Worcester
City or town: Berlin Rural #3
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 60 years
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Worcester
City or town: Berlin Rural #3
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war: No

3.(a) FULL NAME: Samuel J. Simmons

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Colored	Married

6.(b) Name of husband or wife: Sallie Simmons
6.(c) If alive, give age: 82 years

7. Birth date of deceased (mo., day, yr.): May 5 - 1860

8. AGE: Years	Months	Days	If less than one day
85	7	0	hrs. min.

9. Birthplace: Pittsville, Wicomico MD (Town, county, and state)
10. Usual occupation: Farmer
11. Industry or business:
FATHER 12. Name: John Simmons
13. Birthplace: Maryland
MOTHER 14. Maiden name: Julia Simmons
15. Birthplace: Maryland
16. Informant: Elmer J. Simmons
Address: Berlin, Md Rural #3
17. Burial (Burial, cremation, or removal. Which?) Date thereof: Dec. 11/46 (month) (day) (year)
Cemetery or crematory: St. Peters
Location: Newark Rural
18. Funeral director: Hearne & Simmons
Address: Snow Hill, Md
19. 12-27 1945 (Date rec'd by registrar) Helen F. Hayward Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: December 5 1945 at 10 P M
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 12-7 - 45 to 12-8 1945 and that I last saw him alive on 12-8 1945

Immediate cause of death	DURATION
Acute Lobar Pneumonia	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Alfred E. Corbett M. D. or other
Address: Berlin Md Date signed

VS A15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
DEC 29 1945
BUREAU V.E.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 106

CERTIFICATE OF DEATH

1284

Reg. Dist. No. 351

WITHIN CORPORATE LIMITS

1. PLACE OF DEATH:

County: Worcester

City or town: Snowhill (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Life

Hospital, institution, or street address where death occurred: no

How long in hospital or institution? no

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: md County: Worcester

City or town: Snowhill md (If outside city or town limits, write RURAL and give nearest town)

Street No.: market St (If rural, give LOCATION)

2.(a) If veteran, name war: no

3.(a) FULL NAME: Sadie waters

3.(b) Social Security Number: no

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	a.a.	married Divorced

6.(b) Name of husband or wife: Sidney Robins Dead

6.(c) If alive, give age: no years

7. Birth date of deceased (mo., day, yr.): about 1885

8. AGE: Years: about 60 | Months: — | Days: — | If less than one day: ..... hrs. ..... min.

9. Birthplace: Snowhill (Town, county, and state)

10. Usual occupation: Housekeeper

11. Industry or business: Same as above

FATHER 12. Name: George Waters

13. Birthplace: Snowhill

MOTHER 14. Maiden name: Lidia Gallick

15. Birthplace: Snowhill md

18. Informant: Susie Tompkins

Address: Snowhill md

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Dec 18, 1945 (month) (day) (year)

Cemetery or crematory: Ebenezer

Location: Snowhill md

18. Funeral director: James T. Stewart

Address: Salisbury md

19. 12/18/45 (Date rec'd by registrar) Reloy Smith Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Dec 14 1945, at 10-30 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct 1 1945 to Dec 14 1945 and that I last saw h.er alive on Dec 13 1945

Immediate cause of death	DURATION
Lobar Pneumonia.	1 wk
Due to	
Due to	
Other conditions: Hypertension	10 yrs
Right hemiplegia (Include pregnancy within 3 months of death)	6 mos

Major findings of operations: ..... Date of op. .....

Autopsy results: .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: Robt Le Mar NP M. D. or other

Address: Snowhill Date signed: 12/17/45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

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